MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 22, 2002
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Medicare coverage of cardiac rehabilitation programs and pulmonary rehabilitation services
-- Sally Kaplan

MR. HACKBARTH: We are to our last session. Congratulations, Sally, although I think you've got an alert --
* DR. KAPLAN: I won the prize this month, twice.
MR. HACKBARTH: You've got an alert group. We are now taking up Medicare coverage of cardiac rehab programs and pulmonary rehab services.
DR. KAPLAN: Let me start by saying, we're hoping for one bite at this apple, too.
BIPA required MedPAC to study Medicare's coverage of cardiac rehab and pulmonary rehab. The results of this study are due to the Congress in June. At the end of my presentation you will have to decide which of our two suggestions you prefer to respond to this mandate or suggest another alternative or other alternatives.
The BIPA language is included in your mailing materials. The language asks us to focus mainly on clinical issues, qualifying diagnoses, and level of physician supervision. Medicare has covered cardiac rehab programs for beneficiaries with one of three conditions since 1982. In February 2001, using the process established to make national coverage decisions, CMS began evaluating whether coverage for cardiac rehabilitation should be extended to other diagnoses. CMS planned to make the coverage decision by the end of 2001. We planned to assess whether CMS used due diligence in making that decision because we did not feel that MedPAC was the right organization to make clinical coverage decisions.
CMS did not plan on making a national coverage decision about pulmonary rehabilitation. We planned to say that we would review CMS's due diligence when its decision about pulmonary rehabilitation was made.
CMS ran into a dilemma in the process of evaluating the evidence that cardiac rehabilitation was efficacious for other condition. Cardiac rehabilitation is paid as incident to physician services. Direct physician supervision is required for providers to be paid. The evidence, however, suggests that a physician's presence may not be necessary, but without physician supervision the provider could not be paid. CMS requested that the Office of Inspector General determine whether providers are in compliance with the required level of supervision, and recommend what CMS should do to solve their dilemma.
Now we have a dilemma. CMS will not make a decision before our report is due in June. The two options we came up with for solving our dilemma are on the screen. We could send the Congress a letter delaying our response until CMS makes the decision. As a practical matter, we're not the best entity to make clinical coverage decisions. It is not our area of expertise or comparative advantage. Therefore, staff prefer the second option, that we send a letter basically explaining that we are not the best entity to make coverage decisions.

You may have another option. We plan to distribute the letter to you by e-mail after this meeting, so one bite at the apple.

MR. HACKBARTH: I think this makes sense but I just want to pursue it a little bit further. We do a lot of things. We've got a broad agenda and we touch on a lot of things that have clinical implications certainly. Before we give a response that might seem to the sponsors of this particular provision, unresponsive, I'd like to clearly understand why this is different than the other things we do. Could you just elaborate on that for me, Sally?

DR. KAPLAN: I think a good example is the non-physician providers and coverage, whether Medicare should be paying for them. You're making decisions there basically on, shall we say, education, consistency in the program, that type of thing. Here we're being asked to decide what diagnoses would benefit from cardiac rehabilitation, which requires very extensive review of the clinical literature for which CMS has a process on their national coverage decisions.

We also are required to weigh in on the issue of how much supervision physicians should give. That again is another clinical decision. So I just feel that this is different than deciding whether non-physician providers should be covered because in some respects that's going to be an issue of consistency in the program.

DR. ROWE: I support the staff's proposal but I think that it should be stated in such a way as not to try to indicate that MedPAC has no clinical expertise or interest.

DR. KAPLAN: I wasn't suggesting that, Jack.

DR. ROWE: No, but I think that Dr. Loop, a distinguished cardiac surgeon, might have an opinion with respect to cardiac rehabilitation. There are some other doctors or former doctors here as well.

So I think what we really have to say is that while many of the issues that we deal with are clinical, and in fact we talk all the time about the clinical needs of the population and whether the benefit package meets those needs -- I wouldn't go into it saying, we're not interested in things clinical. I would just say that with respect to the technical aspects of making this decision there is an apparatus at CMS. We don't have such an apparatus, and it would be duplicative for us to try to develop such an apparatus, and we don't have the staff that are experts in analyzing this kind of question.

I just want to make sure that we don't try to walk away from all things clinical, because in fact I think many of the things we talk about, including preventive services, hospice care at the end of life, are very clinically-imbedded discussions.

DR. REISCHAUER: Can't we phrase the response in terms of, there's a continuum and this is way down at the end; technical, clinical kind of decision?

DR. ROWE: Just like the U.S. Preventive Services Task Force, this would be another example of whether this preventive service should be included or not. I think we would probably say, why don't we ask them, they're set up to answer that

question; not us. That would be another example that we would punt.

DR. LOOP: If you don't want to say that we don't want to make clinical coverage decisions and you choose the former type letter, you could privately tell CMS there's two publications that can answer their questions. One is Clinical Practice Guidelines, and the other is Guidelines for Cardiac Rehabilitation in Secondary Prevention Programs, Third Edition. The answer is fairly clear in that and they should be able to make a decision soon.

DR. KAPLAN: Let me speak in defense of CMS, which isn't a normal role for me. I think they were ready to make the clinical decision. The problem that they ran into was the direct supervision issue. There's no benefit -- you have to have a benefit category to pay for anything under Medicare. There's a benefit category, for instance, for home health care, for hospice care. There is no benefit category for cardiac rehabilitation services. So the only way you can pay for it is incident to physician services, which requires the direct supervision of physicians.

So what do they do? Do they ask Congress to create a benefit category, which in essence could mean that everybody in the world could get cardiac rehabilitation services without any restriction? Or I think another choice that they presented to the OIG was, do they develop conditions of participation for all cardiac rehab programs? Then the third option was, do they continue to require the direct physician supervision, although perhaps the clinical evidence suggests that it might not be that necessary?

DR. ROWE: I think this is an excellent example of the kind of thing Julian and Jill can include in their chapter when we talk about the changes in the production and the distribution of health care services that are needed by Medicare beneficiaries over time and how that requires some changes in the Medicare program. Here is a specific example of a service that no doubt is very important for beneficiaries but there is this conundrum or dilemma. So I just point this out. I'm sure there are thousands of examples but here's one.

MR. HACKBARTH: So I think where we are, Sally, is with the second bullet with somewhat modified language so that it's not overly broad and saying, we don't do things clinical.

DR. KAPLAN: Okay, thank you.